TUFTS Health Plan

Health Maintenance Organization

Tufts Medicare Complement HMO Plan

Evidence of Coverage

(This is effective July 1, 2003.)

333 Wyman Street

Waltham, MA 02454

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Overview

Introduction

Welcome to the Tufts Health Plan Medicare Complement Plan ("TMC Plan"). We are pleased you have chosen us. We look forward to working with you to help you meet your health care needs. Your satisfaction with Tufts Health Plan ("the Plan") is important to us. If at any time you have questions, please call a Member Services Coordinator at 1-800-870-9488 and we will be happy to help you.

The Tufts Medicare Complement Plan, in conjunction with Medicare, offers a comprehensive package of medical benefits. The TMC Plan is designed to add to existing Medicare coverage (Parts A and B of the Original Medicare Program), subject to the terms, conditions, exclusions and limitations of Medicare eligible services.

Under the TMC Plan, coverage is provided for certain services which are not covered under Medicare. Those services include:

- preventive care, including routine health exams, annual vision and hearing screenings; and
- prescription drug coverage.

Eligibility for Benefits under this TMC Plan

You have chosen to participate in a managed health care network in which you and your Primary Care Physician ("PCP") play the most important roles. Tufts Health Plan is a health maintenance organization which arranges for your health care through a network of health care professionals and hospitals. When you join Tufts Health Plan, you will need to choose a Primary Care Physician ("PCP") to manage your care. Your PCP is a physician in private practice who personally cares for your health needs, and if the need arises, refers you to a specialist within the Tufts Health Plan network.

By joining the TMC Plan, you agree to receive your care from Plan Providers. If you fail to do this:

- the Plan will not provide benefits for either Medicare-eligible services or the additional Covered Services available under this plan, and
- you will be responsible for any Medicare Deductible and Coinsurance amounts.

The Plan covers only the services and supplies described as Covered Services in Chapter 3. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your Effective Date.

Evidence of Coverage

This book, called your Evidence of Coverage, will help you find answers to your questions about Plan benefits. The Plan certifies that you have the right to services and supplies described in this Evidence of Coverage which are Medically Necessary and authorized by your PCP.

The benefits described in this Evidence of Coverage are available as established by Massachusetts General Law Chapter 176G. Under the provisions of the Tufts Medicare Complement Plan, Medicare is the *primary insurer* and the Plan is the *secondary insurer*.

Coverage will be subject to the terms, conditions, exclusions, and limitations of eligible services and supplies under the Original Medicare Plan. That coverage is subject to change per Medicare's guidelines. This Evidence of Coverage is not intended as a full explanation of Medicare's benefits. Information and guidelines established for Medicare by the federal Health Care Financing Administration may be obtained:

- by contacting your local Social Security office; or
- via the internet on the official Medicare web site at **www.medicare.gov**.

In addition, please refer to your Medicare Handbook for any questions pertaining to the Medicare portion of your health care under this TMC plan.

Please note that words with special meanings appear as capitalized words in this Evidence of Coverage. Those words are defined in the Glossary in Appendix A.

Calls to Member Services

The Member Services Department is committed to excellent service.

Calls to the Member Services Department may on occasion be monitored by supervisors to assure quality service.

Translating services for 140 languages

Interpreter and translator services related to administrative procedures are available to assist Members upon request. For information, please call the Member Services Department.

خدمات المترجمين والترجمة المتعلقة بالإجراءات الإدارية متوفرة لمساعدتك في هذا الشأن. لطلب هذه الخدمات، الرجاء الاتصال بقسم علاقات الزبون التابع لخطة "تفتس هلس بلان".

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ នៃគំរោងថែរក្សាសុខភាពរបស់ Tufts ។

相關管理程序的口譯和筆譯服務隨時爲您提供協助。如需要這些服務，請打電話給「Tufts 健康計劃顧客聯絡部」。

Des services d'interprétariat et de traduction liés aux procédures administratives sont disponibles. Pour demander ces services, veuillez contacter le département des relations avec la clientèle de Tufts Health Plan.

Για την εξυπηρέτησή σας, υπάρχουν διαθέσιμες υπηρεσίες ερμηνείας και μετάφρασης σχετικά με τις διοικητικές διαδικασίες. Για να ζητήσετε αυτές τις υπηρεσίες, τηλεφωνήστε στο Τμήμα Πελατειακών Σχέσεων του Προγράμματος Ιατροφαρμακευτικής Ασφάλισης Tufts.

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານຕ່າງດ້ານວິທີດຳເນີນການຫຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts , ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

Temos disponíveis serviços de tradução e interpretação relacionados aos procedimentos administrativos. Para obter estes serviços, ligue para o departamento de relações com o cliente do Tufts Health Plan.

С целью оказать Вам помощь по административным процедурам предлагаются устные и письменные переводческие услуги. Если Вам нужны эти услуги, позвоните, пожалуйста, в Отдел связей с клиентами Плана здравоохранения «Тафтс» Tufts.

Los servicios de traducción e interpretación en relación a procedimientos administrativos están disponibles para ayudarle. Para solicitar este servicio, favor de llamar al departamento de relaciones con el cliente de Tufts Health Plan.

Genyen sèvis tradiksyon ak entèprèt disponib pou ede ou nan zafè ki gen rapò ak jan administrasyon an fè sèvis li. Pou ou mande sèvis sa yo, tanpri rele depatman sèvis kliyan Tufts Health Plan.

Sono disponibili servizi di traduzione e interpretariato relativamente alle procedure amministrative. Per richiedere tali servizi, contattare l'ufficio relazioni clienti del Tufts Health Plan.

1-800-870-9488

TDD

Telecommunications Device for the Deaf:

1-800-815-8580

In this chapter

This chapter contains the following topics.

How the Plan Works

Primary Care Physicians

Each Member must choose a Primary Care Physician (PCP) who will provide or authorize care. If you do not choose a PCP, the Plan will not pay for any services or supplies except for Emergency care.

Medically Necessary services and supplies

The Plan will pay for Covered Services and supplies when they are Medically Necessary.

Important: The Plan will not pay for services or supplies which are not Covered Services, even if they were provided or authorized by your PCP.

The Plan's Service Area

In most cases, you must receive your care in the Service Area. The exceptions are for an Emergency, or Urgent Care while traveling outside of the Service Area.

See the *Directory of Health Care Providers* for the Service Area.

Changes to the Plan's Provider network

The Plan offers Members access to an extensive network of physicians, hospitals, and other Providers throughout the Service Area. Although the Plan works to ensure the continued availability of Plan Providers, the Plan's network of Providers may change during the year.

This can happen for many reasons, including a Provider's retirement, moving out of the Service Area, or failure to continue to meet the Plan's credentialing standards. In addition, because Providers are independent contractors who do not work for the Plan, this can also happen if the Plan and the Provider are unable to reach agreement on a contract.

If you have any questions about the availability of a Provider, please call a Member Services Coordinator at 1-800-870-9488.

Comparison of coverage

The table below tells you if coverage exists, depending on the type of care you receive and the place you receive care.

IF you…	AND you are…	THEN…
receive routine health care services	in the Service Area	you are covered, if you receive care through your PCP.
	outside the Service Area	you are <u>not</u> covered.
are ill or injured	in the Service Area	you are covered, if you receive care through your PCP.
	outside the Service Area	you are covered for Urgent Care.
have an Emergency	in the Service Area	you are covered.
	outside the Service Area	you are covered.

Continuity of Care

If you are an existing Member

If your Provider is involuntarily disenrolled from the Plan for reasons other than quality or fraud, you may continue to see your Provider in the following circumstances:

- *Pregnancy*. If you are in your second or third trimester of pregnancy, you may continue to see your Provider through your first postpartum visit.
- *Terminal Illness*. If you are terminally ill, you may continue to see your Provider until your death.

If your PCP disenrolls, the Plan will provide you notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud, you may continue to see your PCP for up to 30 days after the disenrollment.

To choose a new PCP, call a Member Services Coordinator at 1-800-870-9488. The Member Services Coordinator will help you to select one from the *Directory of Health Care Providers*. You can also visit the Plan's Web site at **www.tuftshealthplan.com** to choose a PCP.

If you are enrolling as a new Member

When you enroll as a Member, if none of the health plans offered by the Group Insurance Commission at that time include your Provider, you may continue to see your Provider if:

- you are undergoing a course of treatment. In this instance, you may continue to see your Provider for up to 30 days from your Effective Date.
- the Provider is your PCP. In this instance, you may continue to see your PCP for up to 30 days from your Effective Date;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your Provider through your first postpartum visit;
- you are terminally ill. In this instance, you may continue to see your Provider until your death.

Conditions for coverage of continued treatment

The Plan may condition coverage of continued treatment upon the Provider's agreement:

- to accept reimbursement from the Plan at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to a Member in an amount that would exceed the cost sharing that could have been imposed if the Provider has not been disenrolled;
- to adhere to the quality assurance standards of the Plan and to provide the Plan with necessary medical information related to the care provided; and
- to adhere to the Plan's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by the Plan.

About Your Primary Care Physician

Importance of choosing a PCP

Each Member must choose a PCP when he or she enrolls. Until you have chosen a PCP, only Emergency care is covered. The PCP you choose will be associated with a specific Provider Unit. This means that you will usually receive Covered Services from health care professionals and facilities associated with that Provider Unit. Once you have chosen a PCP, you are eligible for all Covered Services.

What a PCP does

A PCP:

- provides routine health care (including routine physical examinations),
- arranges for your care with other Plan Providers, and
- provides referrals for other health care services.

Your PCP, or a Covering Physician, is available 24 hours a day.

Your PCP will coordinate your care by: treating you, or referring you to specialty services.

Choosing a PCP

You must choose a PCP from the list of PCPs in the *Directory of Health Care Providers*. If you already have a physician who is listed as a PCP, in most instances you may choose him or her as your PCP.

If you do not have a physician or your physician is not listed in the *Directory of Health Care Providers*, call a Member Services Coordinator at 1-800-870-9488 for help in choosing a PCP.

Notes:

- Under certain circumstances required by law, if your physician is not in the Tufts Health Plan network, you will be covered for a short period of time for services provided by your physician. A Member Services Coordinator can give you more information. Please see "Continuity of Care" on page 1-6.
- For additional information about a PCP or specialist, the **Massachusetts Board of Registration in Medicine** provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 727-0773 or **www.massmedboard.org.**

Contacting your new PCP

If you have chosen a new physician as your PCP, you should:

- contact your new PCP as soon as you join and identify yourself as a new Plan Member,
- ask your previous physician to transfer your medical records to your new PCP, and
- make an appointment for a check-up or to meet your PCP.

If you can't reach your PCP

Sometimes you may not be able to reach your PCP by phone right away. The table below explains what you should do if this happens.

IF…	THEN…
your PCP cannot take your call at once	always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call.
no one answers the telephone or returns your call	call the Plan's 24-hour line at 1-800-870-9488.

Note: You do not need to call your PCP before receiving Emergency Care. See "What to Do in an Emergency" later in this chapter for more information.

Changing your PCP

You may change your PCP or, in certain instances, the Plan may require you to do so. The new physician will not be considered your PCP until:

- you choose a new PCP from the *Directory of Health Care Providers*;
- you report your choice to a Member Services Coordinator at 1-800-870-9488; and
- the Plan approves the change in your PCP.

Then, the Plan will send you a new Member ID card listing your new PCP.

Note: You may not change your PCP while you are an Inpatient or in a partial hospitalization program.

Canceling appoint-ments

If you must cancel an appointment with any Provider:

- always provide as much notice to the Provider as possible (at least 24 hours), and
- if your Provider's office charges for missed appointments that you did not cancel in advance, the Plan will not pay for the charges.

Referrals for specialty services

Every PCP is associated with a specific Provider Unit. If you need to see a specialist, your PCP will select the specialist and make the referral. Usually, your PCP will select and refer you to another Provider in the same Provider Unit (as defined in Appendix A). Because the PCP and the specialists already have a working relationship, this helps to provide quality and continuity of care.

If you need specialty care that is not available within your PCP's Provider Unit (this is a rare event), your PCP will choose a specialist in another Provider Unit and make the referral. When selecting a specialist for you, your PCP will consider any long-standing relationships that you have with any Plan Provider, as well as your clinical needs. (As used in this section, a long-standing relationship means that you have recently been seen or been treated repeatedly by that Plan specialist.)

If you require specialty care which is not available through any Plan Provider (this is a rare event), your PCP may refer you, with the prior approval of an Authorized Reviewer, to a Provider not associated with the Plan.

Notes:

- Covered Services provided by non-Plan Providers are not paid for unless authorized in advance by your PCP and approved by an Authorized Reviewer.
- For mental health and substance abuse services, you may not need a referral from your PCP. See "Inpatient mental health/substance abuse services" and "Outpatient mental health/substance abuse services" later in this chapter for more information.

Referral forms for specialty services

Except as provided below, your PCP must complete a referral every time he or she refers you to a specialist. Sometimes your PCP will ask you to give a referral form to the specialist when you go for your appointment. Your PCP may refer you for one or more visits and for different types of services. Your PCP must approve any referrals that a specialist may make to other Providers. Make sure that your PCP has made a referral before you go to any other Provider. A PCP may authorize a standing referral for specialty health care provided by a Plan Provider.

Authorized Reviewer approval

If the specialist refers you to a non-Plan Provider, the referral must be approved by your PCP and an Authorized Reviewer. In addition, certain Covered Services described in Chapter 3 must be authorized in advance by an Authorized Reviewer. If you do not obtain that authorization, the Plan will not cover those services and supplies.

When referrals are not required

The following Covered Services do not require a referral or prior authorization from your Primary Care Physician.

- Emergency Care in an Emergency Room or physician's office.
- Mammography screenings at the following intervals:
  - one baseline at 35-39 years of age;
  - one every year at age 40 and older; or
  - as otherwise Medically Necessary.
- Pregnancy terminations.
- Routine annual eye exam.
- Spinal Manipulation.
- The following specialty care provided by a Plan Provider who is an obstetrician, gynecologist, certified nurse midwife or family practitioner:
  - Maternity Care.
  - Medically Necessary evaluations and related health care services for acute or Emergency gynecological conditions.
  - Routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be Medically Necessary as a result of that exam.

Financial Arrangements between the Plan and Plan Providers

Methods of payment to Tufts Health Plan Providers

The Plan's goal in compensation of Providers is to encourage preventive care and active management of illnesses. The Plan strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards Providers for providing high quality care to our Members. Tufts Health Plan uses a variety of mutually agreed upon methods to compensate Plan Providers.

The *Directory of Health Care Providers* indicates the method of payment for each Provider. Regardless of the method of payment, the Plan expects all participating Providers to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of Medically Necessary care and reduces the number of unnecessary medical tests and procedures which can be both harmful and costly to Members.

The Plan oversees the provision of care through its Quality of Health Care Program. You should feel free to discuss with your Provider specific questions about how he or she is paid.

Member Identification Card

Introduction

The Plan gives each Member a Member identification card (Member ID).

Reporting errors

When you receive your Member ID, check it carefully. If any information is wrong, call a Member Services Coordinator at 1-800-870-9488.

Using your card

Your Member ID is important because it identifies your health care plan. Please remember to:

- carry your card at all times;
- have your card with you for medical, hospital and other appointments; and
- show your card to any Provider before you receive health care.

Receiving services

When you receive services, tell the office staff that you are a Tufts Health Plan Member.

If you do <u>not</u> do this, and, as a result, your PCP or the Plan does not manage your care, then

- the Plan may <u>not</u> pay for the services provided, and
- you would be responsible for the costs.

Membership requirement

You are eligible for benefits if you are a Member when you receive care. A Member ID alone is not enough to receive you benefits. If you receive care when you are not a Member, you are responsible for the cost.

Utilization Management

Introduction

This section describes the Plan's utilization management program.

Utilization management

Tufts Health Plan has a utilization management program. The purpose of the program is to control health care costs by evaluating whether health care services provided to Members are Medically Necessary and provided in the most appropriate and efficient manner. Under this program, the Plan sometimes engages in prospective, concurrent, and retrospective review of health care services.

The Plan uses prospective review to determine whether proposed treatment is Medically Necessary before that treatment begins.

The Plan engages in concurrent review to monitor the course of treatment as it occurs and to determine when that treatment is no longer Medically Necessary.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, the Plan engages in retrospective review to more accurately determine the appropriateness of health care services provided to Members.

IMPORTANT NOTE: Members can call the Plan at 1-800-870-9488 to determine the status or outcome of utilization review decisions.

Specialty case management

Some Members with Severe Illnesses or Injuries may warrant case management intervention under the Plan's specialty case management program. Under this program, the Plan:

- encourages the use of the most appropriate and cost-effective treatment; and
- monitors the Member's treatment and progress.

The Plan may contact that Member and his or her Plan Provider to discuss a treatment plan and establish short and long term goals. The Tufts Health Plan Specialty Case Manager may suggest alternative treatment settings available to the Member.

The Plan may periodically review the Member's treatment plan. The Plan will contact the Member and the Member's Plan Provider if Tufts Health Plan identifies alternatives to the Member's current treatment plan that: qualify as Covered Services; are cost effective; and are appropriate for the Member.

A Severe Illness or Injury includes, but is not limited to, the following:

- high-risk pregnancy and Newborn Children with serious medical conditions;
- serious heart or lung disease;
- cancer;
- certain neurologic diseases;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- severe traumatic injury.

Individual case management (ICM)

In certain circumstances, the Plan may authorize an individual case management ("ICM") plan for a Member with a Severe Illness or Injury. The ICM plan is designed to arrange for the most appropriate type, level, and setting of health care services and supplies for the Member.

As a part of the ICM plan, the Plan may authorize coverage for alternative services and supplies that do not otherwise constitute Covered Services for that Member. This will occur only if the Plan determines that all of the following conditions are satisfied:

- the Member's condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are Medically Necessary;
- the alternative services and supplies are in place of more expensive treatment that qualifies as Covered Services;
- the Member and an Authorized Reviewer agree to the alternative treatment program; and
- the Member continues to show improvement in his or her condition, as determined periodically by an Authorized Reviewer.

When Tufts Health Plan authorizes an ICM plan, the Plan will also indicate the Covered Service that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the Member would have received for the Covered Service.

The Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the Member. If, at any time, these services and supplies fail to satisfy any of the conditions described above, the Plan may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.

When You Are Ill or Injured (Non-Emergency Care)

Intro-duction

This topic describes what to do when you are ill or injured and you are within the Service Area. This includes when you need Urgent Care within the Service Area.

Rule

Always call your PCP. Without authorization from your PCP, services will not be covered by the Plan.

Important: Never wait until your condition becomes an Emergency to call.

Procedure

If you are ill or injured, follow the steps in the table below.

Step	Action
1	Contact your PCP and say you are a Tufts Health Plan Member.
2	Explain the problem as clearly as possible to the office staff or your PCP.
3	After evaluating your problem, your PCP will: • provide you care, or • arrange for treatment and specialty care if necessary.

Note: If you cannot reach your PCP (or the Covering Physician) after normal business hours, call the Plan's 24-hour line at 1-800-870-9488.

Inpatient hospital services

If you need Inpatient services, in most cases you will be admitted to your PCP's Plan Hospital.

Transfer to a Plan Hospital

If you are admitted to a facility which is not the Plan Hospital in your PCP's Provider Unit, and your PCP determines that transfer is appropriate, you will be transferred to:
- the Plan Hospital in your PCP's Provider Unit, or
- another Plan Hospital.

Important: The Plan may not pay for Inpatient care provided in the facility to which you were first admitted after your PCP has decided that a transfer is appropriate and transfer arrangements have been made.

Inpatient mental health/ substance abuse services

For Inpatient mental health/substance abuse services, each Member will be assigned to a Designated Facility or another Inpatient facility. Assignment is based on each Member's age, as well as the Provider Unit affiliation of that Member's PCP.

Inpatient mental health/ substance abuse services, *continued*

If you live in an area where the Plan's Designated Facilities are available, you will be assigned to one. In this case, the following will apply:

- Your Member ID will list the name and telephone number of your Designated Facility.
- You must call your Designated Facility to receive Inpatient mental health/ substance abuse services. Call a Member Services Coordinator at 1-800-870-9488 for the name and telephone number of your Designated Facility.
- Your Designated Facility will provide or authorize such services for you.
- If you are admitted to a facility which is not your Designated Facility, and the Designated Facility decides that transfer is appropriate, you will be transferred to:
  - your Designated Facility, or
  - another Provider as authorized by the Designated Facility.

Important Notes:

- The Plan will not pay for Inpatient care provided in the facility to which you were first admitted after your Designated Facility has decided that a transfer is appropriate and transfer arrangements have been made.
- If you choose to stay as an Inpatient after your Designated Facility has scheduled your discharge or determined that further Inpatient services are no longer Medically Necessary, the Plan will not pay for any costs incurred after that time.

If you live in an area where the Plan's Designated Facilities are not available, the following will apply:

- You must call your PCP, who will arrange for you to receive Inpatient mental health/substance abuse services.
- A Plan Hospital will provide or authorize such services for you.

Charges after discharge hour

If you choose to stay as an Inpatient after a Plan Provider has scheduled your discharge, the Plan will not pay for any costs incurred after the discharge hour.

Outpatient mental health/ substance abuse services

You may obtain a referral to see an Outpatient mental health and substance abuse provider if you, your PCP, or a Tufts Health Plan mental health Provider calls the Plan's Mental Health/Substance Abuse Referral Service at 1-800-208-9565.

What to Do in an Emergency

Guidelines for receiving Emergency care

Follow these guidelines when you need Emergency care, whether in or out of the Service Area.

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.
- You do not need approval from your PCP before receiving Emergency care.
- If you receive outpatient Emergency care at an emergency facility, you or someone acting for you should call your PCP or the Plan within 48 hours after receiving care. You are encouraged to contact your Primary Care Physician so your PCP can provide or arrange for any follow-up care that you may need.
- If you are admitted as an Inpatient, you or someone acting for you must call your PCP or the Plan within 48 hours after receiving care.
- If you receive Emergency Covered Services from a non-Plan Provider, the Plan will pay up to the Reasonable Charge. You pay the applicable Copayment and any difference between what the Plan paid and what the non-Plan Provider charged for the service.

What to Do When Traveling

Introduction This topic tells you what to do if you need care outside the Service Area. When traveling, you must know the types of services that are not covered by the Plan.

Coverage outside the Service Area The table below lists services that are and are not covered outside the Service Area. See the *Directory of Health Care Providers* for the Service Area.

Type of Service	Example	Coverage
Routine care	• routine general physical examinations; • routine gynecological or obstetrical examinations; • diagnostic tests related to general physical and gynecological examinations; • immunizations to prevent disease; and • other preventive procedures.	Not covered
Elective Inpatient Admissions/Day Surgery	Admissions or surgery that can be safely delayed until you return to the Service Area.	Not covered
Care that could have been foreseen before leaving the Service Area	• deliveries within one month of the due date, including postpartum care; • removal of stitches; and • long-term conditions that need ongoing medical care. Exceptions are on a case-by-case basis. Please call a Member Services Coordinator at 1-800-870-9488.	Not covered
Urgent Care (See Appendix A for examples)	You or someone acting for you notifies your PCP or the Plan within 48 hours after you received care.	Covered
Emergency care (See Appendix A for examples)	When you or someone acting for you should notify your PCP or the Plan within 48 hours after you received care, or as soon as reasonably possible. Note: If you do not choose a PCP, the Plan will not pay for any services or supplies except for Emergency Care.	Covered

Information Resources for Members

Obtaining information about the Plan

The following information about the Plan will be available from the Massachusetts Department of Public Health's Office of Patient Protection:

- A list of sources of independently published information assessing member satisfaction and evaluating the quality of health care services offered by the Plan.
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the Plan during the previous calendar year for which such data has been compiled. This information will contain the 3 most common reasons for voluntary and involuntary disenrollment of those physicians.
- The percentage of premium revenue spent by the Plan for health care services provided to Members for the most recent year for which information is available.
- A report that details the following information for the previous calendar year:
  - the total numbers of filed grievances, grievances denied internally, and grievances withdrawn before resolution; and
  - the total number of external appeals pursued after exhausting the internal grievance process, as well as the resolution of all those external appeals.

How to obtain this information

You can obtain this information about the Plan by contacting the Massachusetts Department of Public Health's Office of Patient Protection in the following ways:

- Call 1-800-436-7757
- Write a letter to the Office. Address it to:

  Department of Public Health
  Office of Patient Protection
  250 Washington Street, 2nd Floor
  Boston, MA 02108

- Send a fax to the Office. Fax # 1-617-624-5046.
- View information at the Office's web site. Go to **www.state.ma.us/dph/opp/**.

Chapter 2

Eligibility

Introduction This chapter tells you who is eligible, how to apply and when coverage starts.

Eligibility

Eligibility rule

You are eligible as a Member only if you meet all of the following criteria, subject to federal law:

- You maintain primary residence in the Service Area and live in the Service Area for at least 9 months in each period of 12 months.
- You are eligible for and enrolled in Medicare Parts A and B as either:
  - a person who is age 65 or older; or
  - a person who is disabled, under age 65, and receiving Social Security disability benefits.
- You meet the Group Insurance Commission's rules and regulations, as well as the Plan's eligibility rules.

Proof of eligibility

The Plan may ask you for proof of your eligibility or continuing eligibility. You must provide the Plan proof when asked. This may include proof of:

- residence, and
- Medicare enrollment.

When to enroll

You may enroll yourself for this coverage only:

- during the annual Open Enrollment Period; or
- within 31 days of the date you are first eligible for this coverage.

Effective Date of coverage

If the Plan accepts your application and receives the needed Premium, coverage starts on the date chosen by your Group. Your Effective Date will be on your Member ID.

If you are an Inpatient on your Effective Date, your coverage starts on the later of:

- the Effective Date, or
- the date the Plan is notified and given the chance to manage your care.

Chapter 3
Covered Services

Overview

Introduction

This chapter describes the health care services and supplies covered under the Tufts Medicare Complement Plan.

In this chapter

This chapter contains the following topics.

When health care services are Covered Services

Health care services and supplies are Covered Services only if they are:

- listed as Covered Services in this chapter;
- Medically Necessary, as determined by the Plan and Medicare;
- consistent with applicable state and federal law;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your PCP, except in an Emergency;
- approved by an Authorized Reviewer, in some cases; and
- in the case of Inpatient mental health/substance abuse services, given or authorized by
  - your Designated Facility, if you have one, or
  - another Plan Hospital, if you are not assigned to a Designated Facility.

IMPORTANT NOTES:

1. If your care is provided or authorized by your PCP, the Plan will pay:
   - the Deductibles and Coinsurance for Medicare-eligible services; and
   - the applicable benefit amount for all other Covered Services.
2. If your care is not provided or authorized by your PCP, the Plan will not cover the costs of any services. Instead, you will be responsible for paying for:
   - any Deductibles and Coinsurance for Medicare-eligible services; and
   - the full amount of any other services which otherwise would have been covered by the Plan under this TMC Plan.

Authorized Reviewer approval

Certain Covered Services described in the table below must be authorized in advance by an Authorized Reviewer. If such authorization is not received, the Plan will not cover those services and supplies.

Covered Services table

Health care services and supplies only qualify as Covered Services if they meet the requirements shown above for "When health care services are Covered Services". The following table (beginning on page 3-3) describes those services that qualify as Covered Services.

Covered Services, Continued

Covered Services table (Part A) The following table describes the Covered Services available to you under Medicare Part A of Original Medicare and the Tufts Medicare Complement Plan ("MCP").

Part A Benefits			
BENEFIT	**Medicare Pays…**	**CARE AUTHORIZED BY YOUR PCP***	
		The Plan Pays…	**You Pay…**
Hospital Inpatient services provided at a Medicare-certified general hospital: • Semiprivate room (private room if Medically Necessary); • Regular nursing services (private duty nursing services are not covered); • Inpatient physician services; • Surgery, including the following services in connection with a mastectomy: (1) reconstruction of the breast affected by the mastectomy; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema). *Prosthetic devices are covered as described under "Durable Medical Equipment". Removal of breast implants is covered when: (1) there is a medical complication related to an implant; or (2) there is documented evidence of auto-immune disease. Note: Cosmetic surgery is not covered.	Days 1-60 in Benefit Period: All Covered Services, except the Part A Deductible.	The Part A Deductible.	Nothing.
	Days 61-90 in Benefit Period: All covered costs, except the hospital coinsurance.	The hospital coinsurance.	Nothing.
	Reserve Days: All Covered Services, except the Reserve Day coinsurance, for 60 extra lifetime Reserve Days.	The Reserve Day coinsurance, for 60 extra lifetime Reserve Days. After the 60 extra lifetime Reserve Days are exhausted, the Plan pays all Covered Services.	Nothing for each of the 60 extra lifetime Reserve Days. Also, you pay nothing for all Covered Services after the Reserve Days are exhausted.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Hospital Inpatient services provided at a Medicare-certified general hospital (continued): • Use of operating and recovery rooms; • Meals, including special diets; • Drugs and medications furnished by the hospital during your stay; • Laboratory tests; • X-rays and other radiological services; • Medical supplies, such as casts, surgical dressings, and splints; • Cost of special care units, including intensive care and coronary care units; • Rehabilitation services, such as physical therapy, occupational therapy, speech pathology services, nuclear medicine, and kidney dialysis; • Maternity care services (no PCP referral required); • Psychiatric and/or psychologist services in a general hospital; • Substance abuse detoxification and rehabilitation services; and • All other Medically Necessary services and supplies.	See page 3-3 above for the amounts paid for these Covered Services by Medicare, by you, and by the Plan.			

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Inpatient blood services The following, provided as part of a covered Inpatient stay in a hospital or Skilled Nursing Facility: • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration.	All Covered Services, **except** for the annual blood deductible. This deductible is for the first 3 pints of unreplaced blood during a calendar year.	The cost of the annual blood deductible.	Nothing.	The cost of the annual blood deductible.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Skilled Nursing Facility (SNF) care Skilled nursing and rehabilitation services performed by or provided under the supervision of licensed nursing personnel: • Semi-private room; • Nursing services; • Meals, including special diets; • Physical, occupational, and speech therapy; • Drugs and medications furnished by the skilled nursing facility during your stay; • Medical supplies, such as casts, surgical dressings, and splints; • Diagnostic services, such as x-rays and laboratory services. Note: Custodial care is not covered by either Medicare or the Plan.	Days 1 to 20 in a Benefit Period: All Covered Services.	Nothing.	Nothing.	Nothing.
	Days 21 to 100 in a Benefit Period: All Covered Services, except for the SNF Coinsurance.	The SNF Coinsurance.	Nothing.	The designated SNF for Coinsurance each day.
	Days 100+ in a Benefit Period: Nothing.	Nothing.	All charges after a 100-day SNF stay.	All charges after a 100-day SNF stay.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**

Home Health Care Services:
• Services provided to a homebound Member in his/her home by a home health agency:
  • Part-time or intermittent skilled nursing care;
  • Physical therapy; and
  • Speech therapy.
• If you need intermittent skilled nursing care, physical therapy, or speech therapy, Medicare may also pay for:
  • Occupational therapy;
  • Part-time or intermittent services of a home health aide;
  • Medical social services; and
  • Medical supplies and Durable Medical Equipment provided by the Home Health Agency.
Note: Custodial Care is not covered by either the Plan or Medicare.
	For nutritional counseling, physician home visits, and inhalation therapy:
	Nothing.
		All Medically Necessary charges.	Nothing.	All Charges.

	For Durable Medical Equipment: 80% of the Medicare-approved amount.	20% of the Medicare-approved amount.	Nothing.	All Charges.
	For All other Covered Home Health Care Services: All Charges.	Nothing.	Nothing.	Nothing.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Inpatient Services at a chronic care or Rehabilitation Facility Acute Inpatient rehabilitation services provided in an Inpatient Rehabilitation Facility. *(continued on next page)*	Days 1-60 in a Benefit Period: All Covered Services, except Part A Deductible.	The Part A Deductible.	Nothing.	The Part A Deductible.
	Days 61-90 in a Benefit Period: All Covered Services, except hospital Coinsurance.	The hospital Coinsurance.	Nothing.	The hospital Coinsurance.
	Reserve Days: All Covered Services, except Reserve Day Coinsurance for 60 extra lifetime Reserve Days.	The Reserve Day Coinsurance, for 60 extra lifetime Reserve Days.	Nothing.	The Reserve Day coinsurance, for 60 extra lifetime Reserve Days.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Inpatient Services at a chronic care or Rehabilitation Facility *(continued from previous page)*	Additional Days: Nothing.	as follows… You could incur Inpatient days that Medicare *pays for* either during a covered Benefit Period or as Reserve Days or *excludes* because they occur (1) outside of covered Benefit Period(s) or (2) after you have exhausted your 60 lifetime Reserve Days. If the total number of these days (covered & excluded combined) is less than 100 in a calendar year, the Plan will cover any additional days in that year to bring the total to 100 days. The Plan will pay all charges for these additional days.	Nothing for any of the *Additional Days* that the Plan covers in a calendar year, as described in the "Plan Pays" column on this page. You pay all charges for any Additional Days not covered by the Plan.	All charges for any of the *Additional Days* that the Plan would normally cover in a calendar year, as described in the "Plan Pays" column on this page. In addition, you pay all charges for any Additional Days that the Plan would not cover.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Hospice care for terminally ill Members with a life expectancy of 6 months or less: • Home care provided by a hospice program, either a private organization or a public agency, with an emphasis on providing comfort and relief from pain, including: physician services, nursing care, medical appliances and supplies, and physical therapy, occupational therapy and speech therapy services; • Services not ordinarily covered by Medicare, including homemaker services, counseling, and certain prescription drugs# provided for pain or symptom relief; and • Inpatient respite care intended to give temporary relief to the person or persons who regularly assist with home care. Covered up to a maximum of 5 consecutive days. #Medicare patients can be charged: a Copayment for these prescription drugs; and Coinsurance for Inpatient respite care.	For each day of Medicare-approved Inpatient respite care (maximum of 5 consecutive days) allowed by Medicare: All Covered Services, except the Medicare Coinsurance.	The Medicare Coinsurance.	Nothing.	The Medicare Coinsurance.
	For each covered prescription drug: All Covered Services, except the Medicare Copayment.	The Medicare Copayment.	Nothing.	The Medicare Copayment.
	For all other Covered Services: All Covered Services.	Nothing.	Nothing.	Nothing.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Covered Services table (Part B) The following table describes the Covered Services available to you under Medicare Part B of Original Medicare and the Tufts Medicare Complement Plan.

Part B Benefits				
		CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**

Preventive care services#
• A baseline mammogram (for women between the ages of 35 and 40).
• Annual mammography screenings (for women age 40 and over).
• Pap smear, including pelvic exam (once every 3 years), or annual coverage for women:
  • at high risk for cervical or vaginal cancer, or
  • of child bearing age who have had a pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality.
	For baseline and annual mammography screenings:
	80% of the Medicare-approved amount.
		20% of the Medicare-approved amount, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

	For Pap Smears (clinical laboratory charge): All Covered Services.	For annual PAP smear not otherwise covered by Medicare.	Nothing.	All Charges after the Medicare payment.
	80% of the Medicare-approved amount for doctor services and all other exams.	20% of the Medicare-approved amount for doctor services and all other exams, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

#Additional Outpatient preventive care services may be provided (outside of Part B) under this plan. For more information, see the "Other Covered Services" benefit beginning on page 3-22 in this "Covered Services" section of Chapter 3.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Preventive care services (continued)# Colorectal cancer screening exam, including: • fecal-occult blood test once every year for persons age 50 and over, • flexible sigmoidoscopy once every four years for persons age 50 and over, and • colonoscopy once every two years for persons at high risk for colorectal cancer.	For the fecal occult blood test: All Covered Services. .	Nothing.	Nothing.	Nothing.
	For all other tests: 80% of the Medicare-approved amount, except for the annual Part B Deductible.	The annual Part B Deductible and 20% of the Medicare-approved amount, minus a $10 Copayment per visit.	A $10 Copayment per visit.	Nothing.
Barium enema – Doctor can substitute for sigmoidoscopy or colonoscopy.	All Covered Services.	Nothing.	Nothing.	All charges after the Medicare payment.
Prostate cancer screening (for men age 50 and over) • digital rectal exam, and • PSA test.	For digital rectal exam: 80% of the Medicare-approved amount, except for the annual Part B Deductible.	The annual Part B Deductible and 20% of the Medicare-approved amount, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.
	For PSA test: All Covered Services.	Nothing.	Nothing.	Nothing.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

#Additional Outpatient preventive care services may be provided (outside of Part B) under this plan. For more information, see the "Other Covered Services" benefit beginning on page 3-22 in this "Covered Services" section of Chapter 3.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Preventive care services (continued)# Vaccinations: • flu shot (1 per year); • pneumonia shot; and Hepatitis B shot for Members at medium to high risk for hepatitis.	For flu and pneumonia shots: All Covered Services.	Nothing.	Nothing.	Nothing.
	For Hepatitis B shots: 80% of the Medicare-approved amount, except for the annual Part B Deductible.	For Hepatitis B shots: The annual Part B Deductible and 20% of the Medicare-approved amount, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.
Bone mass measurement for Members at risk for losing bone mass.	For bone mass measurement: 80% of the Medicare-approved amount, except for the annual Part B Deductible.	The annual Part B Deductible and 20% of the Medicare-approved amount, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

#Additional Outpatient preventive care services may be provided (outside of Part B) under this plan. For more information, see the "Other Covered Services" benefit beginning on page 3-22 in this "Covered Services" section of Chapter 3.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Emergency room care#: Medically Necessary Emergency services obtained in a hospital emergency room **in the United States**. (no PCP referral required)	80% of Medicare-approved Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible and 20% Coinsurance, minus a $50 Copayment per Emergency Room visit.	A $50 Copayment per Emergency Room visit.	All charges after the Medicare payment.
		Note: The $50 Emergency Room Copayment is waived if you are admitted as an Inpatient.		
Outpatient services: • Office visits; • Consultation by specialists, including obstetrical and gynecological services; • Allergy testing and treatment; • Outpatient physical, occupational, and speech therapy; • Medical services and surgery; *(continued on next page)*	80% of Medicare-approved Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible and 20% Coinsurance, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

#See "Other Covered Services" on page 3-22 for information about obtaining Emergency room care **outside of the United States**.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Outpatient services - continued: • Immunizations; • Diagnostic x-ray services; • Diagnostic laboratory services; • Inhalation and other home health therapies; • Radiation therapy; • Manipulation of the spine to correct a dislocation that can be shown by an x-ray. *(continued on next page)*	Diagnostic laboratory services: All Covered Services.	Nothing.	Nothing.	All charges after the Medicare payment.
	All other outpatient services listed on this page: 80% of Medicare-approved Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible and 20% Coinsurance, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Outpatient services – continued: Podiatric services, when Medicare-approved and provided by a doctor of podiatry or surgical chiropody.# #Note: Routine foot care is not covered.	80% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible and 20% Coinsurance, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.
The following dental services: • Trauma care, reduction of swelling, and pain relief, for damage to sound and natural teeth; • Reduction of dislocations or fractures of the jaw;	80% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible and 20% Coinsurance, minus the following Copayments: •$10 per office visit; •$50 per Emergency Room visit.	A $10 Copayment per office visit OR A $50 Copayment per Emergency Room visit.	All charges after the Medicare payment.
Inpatient or ambulatory surgical services due to non-dental medical condition that requires you to be in a hospital when you receive dental care.	80% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible and 20% Coinsurance.	Nothing.	All charges after the Medicare payment.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**

Physical therapy, occupational therapy, and speech pathology services, when provided:
• in the following facilities:
  • clinic,
  • hospital,
  • rehabilitation facility, or
  • SNF;
• by a home health agency; or
• by an independent practicing therapist.
	80% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible, and 20% Coinsurance, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

Outpatient blood services • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration.	80% of Covered Services, except for the annual Blood Deductible and the annual Part B Deductible.	The cost of the annual Blood Deductible and the annual Part B Deductible, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payments.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Ambulance services: Transportation between: • your home and a hospital; • your home and a SNF; or • a hospital and a SNF; if: • the ambulance and personnel meet Medicare requirements; and • transportation in any other vehicle could endanger your health.	80% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible, and 20% Coinsurance.	Nothing.	All charges after the Medicare payment.
Durable Medical Equipment (DME): Includes coverage for devices or instruments of a durable nature that: • are reasonable and necessary to sustain a minimum threshold of independent daily living; • are made primarily to serve a medical purpose; • are not useful in the absence of illness or injury; • can withstand repeated use; and • can be used in the home. Note: Includes breast prostheses (including surgical brassiere after a mastectomy.)	80% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible, and 20% Coinsurance.	Nothing.	All charges after the Medicare payment.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Medical supplies: Examples of Covered Services are dressings, splints, and casts.	80% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible, and 20% Coinsurance.	Nothing.	All charges after the Medicare payment.
The following equipment for use in diabetes monitoring by Medicare beneficiaries with diabetes: Blood glucose monitors, test strips, lancets, and self-management.	80% of Medicare-approved Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible and 20% of the Medicare-approved amount .	Nothing	All charges after the Medicare payment.
Comprehensive Outpatient Rehabilitation Facility (CORF): Outpatient rehabilitation services provided at a Comprehensive Outpatient Rehabilitation Facility (CORF).	80% of Covered Services, except for the annual Part B Deductible (subject to the CORF calendar year maximum benefit limit for combined physical therapy and occupational).	The annual Part B deductible, and 20% Coinsurance, subject to the CORF calendar year maximum benefit limit.	All charges after the calendar year CORF maximum benefit limit.	All charges after the Medicare payment.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Mental health and substance abuse services table (Parts A and B)

The following table describes the mental health and substance abuse services available to you under Medicare Parts A and B of Original Medicare and the Tufts Medicare Complement Plan.

Mental Health and Substance Abuse services (Parts A and B)				
		CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Inpatient mental health and substance abuse services (Part A): Inpatient hospital and physician services for the treatment of a mental condition or substance abuse. These services must be provided in a psychiatric or substance abuse facility.	Days 1 to 190 (lifetime): All Covered Services, except for the annual Part A Deductible.	The Part A Deductible.	Nothing.	All charges after the Medicare payment.
	After 190-day Medicare lifetime maximum exhausted: Nothing.	All Covered Services.	Nothing.	All charges.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Mental Health and Substance Abuse services (Parts A and B) (continued)				
		CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**Medicare Pays…**	**The Plan Pays…**	**You Pay…**	**You Pay…**
Outpatient mental health and substance abuse services (Part B): Outpatient services for the treatment of a mental condition or substance abuse. Note: Covered Outpatient mental health services include psychopharmacological services.	50% of Covered Services, except for the annual Part B Deductible.	The annual Part B Deductible, and 50% Coinsurance, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services table The following table describes the services which the Plan covers, but Original Medicare may not cover. The Plan is required under Massachusetts law to cover some of these services.

Other Covered Services (outside of Medicare Parts A and B)			
	CARE AUTHORIZED BY YOUR PCP		**CARE NOT AUTHORIZED BY YOUR PCP***
Benefit	**The Plan Pays…**	**You Pay…**	**You Pay…**
Preventive care services: • Routine physical exams, including appropriate immunizations and lab tests as recommended by the physician; • routine annual eye exam (no PCP referral required); and • hearing exams and screenings.	All Covered Services, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges.
Emergency room care: Medically Necessary Emergency services obtained in a hospital Emergency room **outside of the United States** (no PCP referral required). Note: If you are admitted to the hospital, the Copayment will be waived.	All Covered Services, minus a $50 Copayment per Emergency Room visit.	A $50 Copayment per Emergency Room visit.	The Plan pays for all Covered Services, minus a $50 Copayment per Emergency Room visit.

#See page 3-14 in "Part B Benefits" above for information about obtaining Emergency room care **within the United States**.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
Benefit	**The Plan Pays…**	**You Pay…**	**You Pay…**

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Coverage is provided as described in this section for Outpatient contraceptive services, including consultations, examinations, procedures and medical services, which are related to the use of all contraceptive methods that have been approved by the United States Food and Drug Administration. <u>Family planning</u>: Procedures: • sterilization; and • pregnancy termination, as permitted under Massachusetts law (no PCP referral required). Services: • medical examinations; • birth control counseling; and • genetic counseling. Contraceptives: Cervical caps; Intrauterine devices (IUDs); Levonorgestrel (Norplant®); and Depo-Provera.	All Covered Services, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges.

*<u>Note</u>: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
Benefit	**The Plan Pays…**	**You Pay…**	**You Pay…**
Cardiac rehabilitation: Services for Outpatient treatment of documented cardiovascular disease that: (1) meet the standards promulgated by the Massachusetts Commissioner of Public Health; and (2) are initiated within 26 weeks after diagnosis of cardiovascular disease. The Plan covers only the following services: • the Outpatient convalescent phase of the rehabilitation program following hospital discharge; and • the Outpatient phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise. Note: The Plan does not cover the program phase that maintains rehabilitated cardiovascular health.	All Covered Services.	Nothing.	All charges.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
Benefit	**The Plan Pays…**	**You Pay…**	**You Pay…**
Coronary Artery Disease Program: Coronary Artery Disease secondary prevention program. This program is designed to assist you in making necessary lifestyle changes that can reduce your cardiac risk factors. Note: This program is available at designated programs when Medically Necessary to Members with documented Coronary Artery Disease who meet the clinical criteria established for this program. For more information about this program, Members should call a Member Services Coordinator at 1-800-870-9488.	All Covered Services, except for 10% Coinsurance.	10% Coinsurance.	All charges.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued			
Benefit	**CARE AUTHORIZED BY YOUR PCP**		**CARE NOT AUTHORIZED BY YOUR PCP***
	The Plan Pays…	**You Pay…**	**You Pay…**
Hemodialysis: The Plan covers the following hemodialysis services and supplies, when Medically Necessary and provided on an Outpatient basis: (1) Services, equipment, and supplies necessary to perform dialysis; (2) Routine dialysis monitoring, lab, and other tests; and (3) Installation and maintenance of a dialyzer or deonizer. Important Notes: • Outpatient Services will qualify as Covered Services only if they are provided at a Plan Provider or other Plan-designated facility. • Services provided at the Member's home will qualify as Covered Services only if they are provided by a Plan-designated vendor and when authorized by a Plan Physician.	Covered *Outpatient Services* for Items (1) and (2) described in this benefit: All Covered Services.	Nothing.	All charges.
	Covered *Home Services* for Items (1) and (2): All Covered Services.	Nothing.	All charges.
	Covered *Home Services* for Item (3): • The first $300 of Covered Services; and • 50% of the Reasonable Charge any additional Covered Services.	• Nothing for the first $300 of Covered Services; and • 50% of the Reasonable Charge any additional Covered Services.	All charges.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
Benefit	**The Plan Pays…**	**You Pay…**	**You Pay…**
Bone marrow transplants for breast cancer (must be approved by an Authorized Reviewer): Bone marrow transplants for Members diagnosed with breast cancer that has progressed to metastatic disease who meet the criteria established by the Massachusetts Department of Public Health.	All Covered Services.	Nothing.	All charges.
Nonprescription enteral formulas: For home use for treatment of malabsorption caused by: • Crohn's disease; • ulcerative colitis; • gastroesophageal reflux; • gastrointestinal motility; and • chronic intestinal pseudo-obstruction.	All Covered Services.	Nothing.	All charges.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued			
Benefit	**CARE AUTHORIZED BY YOUR PCP**		**CARE NOT AUTHORIZED BY YOUR PCP***
	The Plan Pays…	**You Pay…**	**You Pay…**
Human Leukocyte Antigen Testing: Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a Member's bone marrow transplant donor suitability. Includes: • costs of testing for A, B or DR antigens; or • any combination consistent with the rules and criteria established by the Department of Public Health.	All Covered Services.	Nothing.	All charges.
Low Protein Foods: When given to treat inherited diseases of amino acids and organic acids.	All Covered Services, up to a maximum benefit of $2,500 per calendar year.	You pay for all Covered Services, **after** the $2,500 calendar year maximum benefit has been reached.	All charges.
Special Medical Formulas: When Medically Necessary to protect the unborn fetuses of women with PKU.	All Covered Services.	Nothing.	All charges.
Hearing Aids: Hearing aids (including fittings) are covered when Medically Necessary and prescribed by a physician. The Plan will only cover one hearing aid per Member every two years.	• The first $500 of Covered Services; and then • 80% of the next $1,500 in Covered Services.	• Nothing for the first $500 of Covered Services; and then • 20% of the next $1,500 in Covered Services.	All charges.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
Benefit	**The Plan Pays…**	**You Pay…**	**You Pay…**
Scalp hair prostheses or wigs for cancer or leukemia patients: Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.	All Covered Services, up to a maximum benefit of $350 per calendar year.	For all services **after** the $350 calendar year maximum benefit has been reached.	All charges.
Patient care services provided pursuant to a qualified clinical trial As required by Massachusetts law, patient care services provided pursuant to a qualified clinical trial for the treatment of cancer to the same extent as those Inpatient or Outpatient services would be covered if the Member did not receive care in a qualified clinical trial.	Inpatient care: All Covered Services Outpatient care: All Covered Services, minus a $10 Copayment per visit.	Inpatient care: Nothing. Outpatient care: A $10 Copayment per visit.	Inpatient care: All charges. Outpatient care: All charges.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - **continued**			
Benefit	**PRESCRIPTION DRUGS THAT…**		
	QUALIFY AS COVERED SERVICES, AS DESCRIBED BELOW.		**DO NOT QUALIFY AS COVERED SERVICES, AS DESCRIBED BELOW.**
	The Plan Pays…	**You Pay…**	**You Pay…**
Prescription Drug Benefit, as described below.	All Covered Services, except for the applicable Copayment below.	The applicable Copayment shown below for covered prescription drugs.	All charges.

PRESCRIPTION DRUG BENEFIT

Introduction: This section describes the prescription drug benefit. The following topics are included in this section to explain your prescription drug coverage: *How Prescription Drugs Are Covered*; *Prescription Drug Coverage Table*; *What is Covered*; *What is Not Covered*; *Pharmacy Management Programs*; and *Filling Your Prescription*. Capitalized words are defined in Glossary in Appendix A.

How Prescription Drugs Are Covered: Prescription drugs will be considered Covered Services only if they comply with the *Pharmacy Management Programs* section described below and are: listed below under *What is Covered*; provided to treat an injury, illness, or pregnancy; Medically Necessary; and written by a Plan participating physician, except in cases of authorized referral or in Emergencies.

For a current list of covered drugs, please go to the Plan's Web site at **www.tuftshealthplan.com,** or call a Member Services Coordinator at 1-800-870-9488. For a list of non-covered drugs, please see Appendix B.

The *Prescription Drug Coverage Table* below describes your prescription drug benefit amounts.

- Tier-1 drugs have the lowest Copayment; most generic drugs are on Tier-1.
- Tier-2 drugs have the middle Copayment.
- Tier-3 drugs have the highest Copayment.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

Where to fill prescriptions: You can fill your prescriptions at any Plan designated pharmacy. Plan designated pharmacies include:

- for the majority of prescriptions, most of the pharmacies in Massachusetts and additional pharmacies nationwide; and
- for a select number of drug products, a small number of designated pharmacy providers. If you have questions about where to fill your prescription, call Member Services at 1-800-870-9488.

How to fill prescriptions:

- Make sure the prescription is written by a Plan participating physician, except in cases of authorized referral or in Emergencies.
- When you fill a prescription, provide your Member ID to any Plan designated pharmacy.
- If the retail cost of your prescription is less than your Copayment, then you are responsible for the actual retail cost.
- If you have any problems using this benefit at a Plan designated pharmacy, call Member Services at 1-800-870-9488.

Important: Your prescription drug benefit is honored only at Plan designated pharmacies. In cases of Emergency, please call Member Services at 1-800-870-9488 for instructions about submitting your prescription drug claims for reimbursement.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

Filling Prescriptions for Maintenance Medications:

If you are required to take a *maintenance* medication, the Plan offers you two choices for filling your prescription medications:

- you may obtain your maintenance medication directly from a Plan designated retail pharmacy; or
- you may have most maintenance medications# mailed to you through a Plan designated mail services pharmacy.

#The following may not be available to you through a Plan designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of the Plan's Dispensing Limitations program; or
- medications that are part of the Plan's Special Designated Pharmacy program.

Note: Your Copayments for maintenance medications are shown in the *Prescription Drug Coverage Table* below.

Continued on next page

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued	
PRESCRIPTION DRUG COVERAGE TABLE	
Benefit Description	**Coverage**
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a Plan designated retail pharmacy.	**Tier-1 drugs**: • $8 for up to a 30-day supply • $20 for a 31-60 day supply • $35 for a 61-90 day supply **Tier-2 drugs:** • $16 for up to a 30-day supply • $40 for a 31-60 day supply • $70 for a 61-90 day supply **Tier-3 drugs:** • $24 for up to a 30-day supply • $60 for a 31-60 day supply • $105 for a 61-90 day supply
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Maintenance Medications, when mailed to you through a Plan designated mail services pharmacy.	**Tier-1 drugs**: $16 for up to a 90-day supply **Tier-2 drugs:** $40 for up to a 90-day supply **Tier-3 drugs:** $70 for up to a 90-day supply

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

What Is Covered:

The Plan covers the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under *What is Not Covered* (see "Important Notes" on page 3-37 below).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Retin-A ® and similar prescription drug products for individuals through the age of 25.
- Oral contraceptives and diaphragms#.

  # Note: This Prescription Drug Benefit only describes coverage for oral contraceptives and diaphragms. See "Family Planning" earlier in this chapter for information about other contraceptive drugs and devices that qualify as Covered Services.

- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the commissioner of insurance.

Note: Certain prescription drugs products may be subject to one of the *Pharmacy Management Programs* described on page 3-36 below.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

What Is Not Covered:

The Plan does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the *What is Covered* section above).
- Drugs that are not listed in Appendix B ("Non-Covered Drugs With Suggested Alternatives") at the end of this Evidence of Coverage.
- Vitamins and dietary supplements (except prescription prenatal vitamins).
- Topical and oral fluorides for adults.
- Contraceptive devices and preparations other than oral contraceptives and diaphragms.

  Note: Covered Services for cervical caps, intrauterine devices (IUDs), Lenorgestrel (Norplant®), and Depo-Provera, are provided as Outpatient care under the Family Planning" benefit described on page 3-23 in this chapter.
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under Preventive health care earlier in this chapter.
- Prescriptions written by physicians who do not participate in the Plan, except in cases of authorized referral or Emergency care.
- Prescriptions filled at pharmacies other than Plan designated pharmacies, except for Emergency care.
- Smoking cessation agents.
- Drugs for asymptomatic onchomycosis, except for Members with diabetes, vascular compromise, or immune deficiency status.
- Retin-A ® and similar prescription drug products for individuals 26 years of age or older, unless Medically Necessary.
- Injectable medications, except as described earlier in this chapter.
- Drugs which are dispensed in an amount or dosage that exceeds the Plan's established dispensing limitations.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Other Covered Services (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUG BENEFIT - continued

Pharmacy Management Programs:

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, the Plan has developed the following Pharmacy Management Programs:

Dispensing Limitations Program:

The Plan limits the quantity of selected medications that Members can receive, for cost, safety and/or clinical reasons.

Preauthorization Program:

The Plan restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from the Plan for such drugs.

Special Designated Pharmacy Program:

The Plan has designated special pharmacies to supply a select number of medications including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C and growth hormone deficiency. These pharmacies specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for Members. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time.

Non-Covered Drugs with Suggested Alternatives*:

While the Plan covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. These non-covered drugs are listed in Appendix B. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are no longer covered.

*Also referred to as "Prescription Alternative Program"

New-To-Market Drug Evaluation Process:

The Plan's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. The Plan then makes a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.
A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

Pharmacy Management Programs, continued

IMPORTANT NOTES:

- If your physician feels it is Medically Necessary for you to take medications that are restricted under any of the *Pharmacy Management Programs* described above, he or she may submit a request for coverage. The Plan will approve the request if it meets Plan guidelines for coverage. For more information, call Member Services at 1-800-870-9488.
- The Plan's Web site has a list of covered drugs with their tiers. The Plan may change a drug's tier during the year. For example, if a brand drug's patent expires, the Plan may move the brand drug from tier 2 to tier 3 when the generic drug becomes available. Most generic drugs are available on tier 1.

If you have questions about your prescription drug benefit or would like to know the tier of a particular drug, check the Plan's Web site at **www.tuftshealthplan.com** or call Member Services at 1-800-870-9488.

*Note: When care is **not** provided or authorized by your PCP, the Plan does not pay for any services or supplies other than Medically Necessary Emergency services (as described on pages 3-14 and 3-22).

List of exclusions

The Plan will not pay for the following services, supplies, or medications:

- A service, supply or medication which is not Medically Necessary.
- A service, supply or medication which is not a Covered Service.
- A service, supply or medication received outside the Service Area, except as described under “How the Plan Works” in Chapter 1.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person’s, personal comfort or convenience.
- Custodial Care.
- Services related to non-covered services.
- A drug, device, medical treatment or procedure (collectively "treatment") that is Experimental or Investigative.

  This exclusion does not apply to:
  - bone marrow transplants for breast cancer;
  - patient care services provided pursuant to a qualified clinical trial; or
  - off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS;

  which meet the requirements of Massachusetts law.

  If the treatment is Experimental or Investigative, the Plan will not pay for any related treatments which are provided to the Member for the purpose of furnishing the Experimental or Investigative treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described in a Prescription Drug Benefit earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered under the Prescription Drug Benefit.
- Injectable medications, except as described earlier in this chapter.

Continued on next page

List of exclusions (continued)

- Services provided by your relative (by blood or marriage) unless the relative is a Plan Provider and the services are authorized by your PCP. If you are a Plan Provider, you cannot provide or authorize services for yourself or be your own PCP for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise Medically Necessary. Examples of a third party are: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Facility charges or related services if the procedure being performed is not a Covered Service.
- Preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under “dental services” earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea, as described in Chapter 3), including those for TMJ disorders.
- Surgical removal or extraction of teeth, except as provided under “dental services” earlier in this chapter.

Continued on next page

List of exclusions (continued)

- Cosmetic surgery, procedures, supplies, medications or appliances used to improve appearance and/or self-esteem.
- Rhinoplasty; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags.
- Hair removal, except when Medically Necessary to treat an underlying skin condition.
- Costs associated with home births.
- Infertility services, infertility medications, and associated reproductive technologies (such as IVF, GIFT, and ZIFT) including, but not limited to, experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days) sperm or embryo cryopreservation not associated with active infertility treatment; donor recruitment fee for donor egg or donor sperm; and Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- Human organ transplants, except as described earlier in this chapter.
- Services given to a non-Member, except as described earlier in this chapter:
  - for organ donor charges under “Human organ transplants”; or
  - for bereavement counseling services under “Hospice care services.”
- Acupuncture; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; Inpatient and Outpatient weight-loss programs and clinics; relaxation therapies; massage therapies; services by a personal trainer; cognitive rehabilitation programs; cognitive retraining programs. Also excluded are diagnostic services related to any of these procedures or programs.

Continued on next page

List of exclusions (continued)

- Blood, blood donor fees, blood storage fees, or blood substitutes; blood products except for: factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease, and intravenous immunoglobulin (Gamimune, Gammagard SD, Gammar-IV, Iveegam, Sandoglobulin, Venoglobulin-I/S, Cytogram, Polygam) for treatment of severe immune disorders, certain neurologic conditions, infectious conditions and bleeding disorders.

- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

- Examinations, evaluations or services for educational or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in this chapter. Also services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting.

- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described earlier in this chapter, the Plan will not pay for contact lenses or contact lens fittings.

- Hearing aids, except as described earlier in this chapter.

- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet.

  Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the Member's treating doctor, and the shoes and inserts:

  - are prescribed by a Provider who is a podiatrist or other qualified doctor; and
  - are furnished by a Provider who is a podiatrist, orthotist, prosthetist, or pedorthist.

- Transportation, except as described in "Ambulance Services" in this Chapter; lodging related to receiving any medical service.

Chapter 4
When Coverage Ends

Overview

Introduction

This chapter tells you when coverage ends.

Reasons coverage ends

Coverage ends when any of the following occurs:

- you lose eligibility because you
  - no longer meet the Group Insurance Commission's or the Plan's eligibility rules,
  - no longer are eligible for and enrolled in Parts A and B of Medicare (please refer to your Medicare Handbook for events that can change your Medicare coverage), or
  - move out of the Service Area,
- you choose to drop coverage,
- you commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to: any Provider; any Member; or the Plan or any Plan employee, or
- The Group Insurance Commission's Contract with the Plan ends.

Benefits after termination

The Plan will not pay for services you receive after your coverage ends even if

- you were receiving Inpatient or Outpatient care when your coverage ends, or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends.

In this chapter

This chapter contains the following topics.

When a Member is No Longer Eligible

Loss of eligibility

Your coverage ends on the date you

- no longer meet the Group Insurance Commission's or the Plan's eligibility rules, or
- no longer are eligible for and enrolled in Parts A and B of Medicare.

If you move out of the Service Area

If you move out of the Service Area, coverage ends as of the date you move.

Tell your Group or call a Member Services Coordinator before you move to notify the Plan of the date you are moving. If you keep a residence in the Service Area but have been out of the Service Area for more than 90 days, coverage ends 90 days after the date you left the Service Area.

For more information about coverage available to you when you move out of the Service Area, tell your group and contact a Member Services Coordinator at 1-800-870-9488.

You choose to drop coverage

Coverage ends if you decide you no longer want coverage. To end your coverage, notify the Group Insurance Commission at least 30 days before the date you want your coverage to end. You must pay Premiums up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

The Plan may terminate your coverage if you commit acts of physical or verbal abuse which:

- are unrelated to your physical or mental condition;
- pose a threat to:
  - any Provider,
  - any Member, or
  - the Plan or any Plan employee.

Voluntary and Involuntary Disenrollment Rates for Members

Voluntary and Involuntary Disenroll-ment Rates for Members

As required by Massachusetts law, the Plan conducts an annual disenrollment study. Annually, the study looks at the reasons Members leave Tufts Health Plan, in order to track voluntary and involuntary disenrollment rates.

- **Voluntary Disenrollment Rate -** The number of Members the Plan disenrolled because they ceased to pay Premiums. This is the voluntary disenrollment rate. For the year 2002, less than one half of one percent (0.32%) of Members voluntarily disenrolled by ceasing to pay their Premiums.
- **Involuntary Disenrollment Rate -** The number of Members that the Plan disenrolled because of fraud or acts of physical or verbal abuse. This is the involuntary disenrollment rate. For the year 2002, the Plan did not involuntarily disenroll any Members as a result of fraud or abuse.

For additional information about the voluntary and involuntary disenrollment rates among Tufts Health Plan Members, you can call Member Services at 1-800-870-9488.

Termination of the Group Contract

Termination

This topic describes the end of the Group Contract.

End of relationship between the Plan and the Group Insurance Commission

Coverage will terminate if the relationship between the Group Insurance Commission and the Plan ends for any reason, including:

- the Commission's contract with the Plan terminates;
- the Commission fails to pay Premiums on time;
- the Plan stops operating; or
- the Commission stops operating.

Chapter 5
Member Satisfaction

Overview

Introduction

This chapter contains information about:

- the Member satisfaction process addressing complaints and appeals about a payment for service or a request for coverage;
- concerns about quality of medical care;
- administrative concerns about the Plan;
- bills from Providers; and
- limitation on actions.

Address and telephone number

If you write to the Plan, send the letter to the attention of a specific person or the Appeals and Grievances Department at this address:

Tufts Health Plan
Attn: Appeals and Grievances Dept.
333 Wyman Street
P.O. Box 9112
Waltham, MA 02454-9112

If you need to call the Plan about a concern or appeal, contact a Member Services Coordinator at 1-800-870-9488.

In this chapter

This chapter contains the following topics.

Member Satisfaction Process

Process Summary

The Plan has a multi-level Member satisfaction process:

- Internal Inquiry;
- Internal Grievance; and
- Office of Patient Protection panel review.

Process: Step-By-Step

Follow the steps in the table below if you have a concern about a payment for service or a request for coverage. You may designate someone to act on your behalf.

Step	Action
1 **Internal Inquiry**	Call a Member Services Coordinator at 1-800-870-9488 to discuss the matter. Every effort will be made to resolve your concerns within 3 business days. If your concern cannot be resolved within 3 business days or you tell the Member Services Coordinator that you are not satisfied with the response you have received from the Plan, the Plan will notify you in writing and describe any grievance options you may have, including the right to have your inquiry processed as an internal grievance, having an oral grievance reduced to writing, and receiving written acknowledgement and written resolution of the grievance in accord with the timelines outlined in Step 5 (see below). The internal inquiry process may not be used for review of an adverse determination. Specifically, if you are requesting coverage for a service or supply that has been reviewed and denied based on medical necessity and you would like to appeal this decision, follow the steps for the internal grievance process described below. In addition, if you are requesting coverage for a specifically excluded service or supply, follow the steps for the internal grievance process set forth below. You will receive a written acknowledgement and resolution of your grievance. The Plan maintains records of each inquiry made by a Member or by that Member's authorized representative. The records of these inquiries and the response provided by the Plan are subject to inspection by the Commissioner of Insurance and the Department of Public Health. **Important Note:** In many instances, the Plan will ask you to direct your initial concern to Medicare (since Medicare will make the primary determination on your health care benefits). Information is available by contacting your local Social Security office or via the internet on the official Medicare web site at **www.medicare.gov**.

Process: Step-By-Step (continued)

Step	Action
2	Were you satisfied with the initial response to your concerns? • If yes, then the process is finished. • If no, you can file a grievance. Go to the next step.
3 **Tufts Health Plan Internal Grievance**	It is important that you contact the Plan as soon as possible to explain your concern. You have 180 days from the date you were notified o the denial of benefit coverage or claim payment to file an internal appeal. Call a Member Services Coordinator who will document your concern and forward it to an Analyst in the Appeals and Grievance Department. To accurately reflect your concerns, the Plan encourages you to put your grievance in writing. Your explanation should include: • Your name and address; • your Member ID number; • a detailed description of your concern (including relevant dates, any applicable medical information, and Provider names); and • any supporting documentation.
4	Mail the letter to the Plan's Appeals and Grievances Department. Address it to: Tufts Health Plan Attn: Appeals and Grievances Dept. 333 Wyman Street P.O. Box 9112 Waltham, MA 02454-9112

Process: Step-By-Step (continued)

Step	Action
5	**<u>Results</u>:** • Within 3 business days after receiving your letter, the Plan will notify you that your letter has been received and provide you with the name, address, and telephone number of the person coordinating the review of your grievance. • If you filed your grievance verbally, within 48 hours the Plan will send you a written confirmation of our understanding of your grievance. The Plan will also include the name, address, and telephone number of the person coordinating the review of your grievance. • If your grievance requires the review of medical records you will receive a form authorizing the release of medical and treatment information relevant to your grievance. You must sign and return the form before the Plan can begin the review process. If you do not sign and return the form to the Plan within no more than 30 calendar days of the date you filed your grievance, the Plan may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance, which are in the possession and control of the Plan. • If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the 30 calendar day review period will begin the day following the end of the 3 day internal inquiry process or earlier if you notify the Plan that you are not satisfied with the response you received during the internal inquiry process. • The Plan will meet to review your grievance, will make a decision, and will send you a letter within no more than 30 calendar days after the Plan received your grievance. • Grievances will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance. • If the case involves an adverse determination (medical necessity determination), an actively practicing practitioner in the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment and who did not participate in any of the prior decisions on the case will participate in the review. • The time limits in this process may be waived or extended by mutual written agreement between you or your authorized representative and the Plan.

Process: Step-By-Step (continued)

Step	Action
5 ***continued***	• If your grievance concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at the Plan's expense through completion of the internal grievance process. Ongoing coverage or treatment includes only that medical care which, at the time it was initiated, was authorized by the Plan and does not include medical care which was terminated pursuant to a specific time or episode-related exclusion from this Evidence of Coverage. • A grievance not properly acted on by the Plan within the time limits of this process, including any extensions made by mutual written agreement between you, your authorized representative and the Plan, shall be deemed resolved in your favor. Note: You may also appear in person or by conference call to present your grievance. To do so, you must request this. An Appeals and Grievance Coordinator will contact you to schedule a date and time to appear. You may bring one person with you when you appear. • The letter you receive from the Plan will include identification of the specific information considered and an explanation of the basis for the decision. A denial letter regarding a final adverse determination will include: the specific information upon which the adverse determination was based; your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; notification of the procedures for requesting review by the Office for Patient Protection; and the titles and credentials of the individuals who reviewed the case.

Process: Step-By-Step (continued)

Step	Action
6	Are you satisfied with the Plan's decision? • **If <u>yes</u>**, then the process is finished. • **If <u>no</u>**, and in circumstances where relevant medical information (1) was received too late to review within the thirty (30) calendar day time limit; or (2) was not received but is expected to become available within a reasonable time period following the written resolution, you may choose to request a reconsideration. The Plan may, in its discretion, allow the opportunity for reconsideration of a final adverse determination. If you request a reconsideration you must agree in writing to a new time period for review, but in no event greater than thirty (30) calendar days from the agreement to reconsider the grievance. Whether or not you seek reconsideration under this paragraph is voluntary, and failure to seek reconsideration will not be deemed failure to complete the Plan's Internal Grievance Process under the "Limitation on Actions" section found in Chapter 5 (see page 5-10) of this Evidence of Coverage. • **If <u>no</u>**, you may be able to obtain further review by a review panel under contract with the Massachusetts Department of Public Health's Office of Patient Protection. See Step 7 below for information about how to contact the Office of Patient Protection.

7 **Review By Office of Patient Protection Review Panel**	Contact the Massachusetts Department of Public Health's Office of Patient Protection as follows: • ***Phone****: 1-800-436-7757* • ***Fax:*** *1-617-624-5046* • ***Internet****:* ***www.state.ma.us/dph/opp*** • ***Street Address:*** *Department of Public Health, Office of Patient Protection, 250 Washington Street, 2nd Floor, Boston, MA 02108* Note: The Office of Patient Protection, which is not connected in any way with Tufts Health Plan, administers an independent external review process for final coverage determinations based on medical necessity. To request an external review by the Office of Patient Protection you must file your request in writing with the Office of Patient Protection within forty-five (45) days of your receipt of written notice of the denial of your grievance by the Plan. You or your authorized representative, if any, may request to have your request for review processed as an expedited external review. Any request for an expedited external review shall contain a certification, in writing, from a physician, that delay in the providing or continuation of health care services, that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review. Your cost for an external review by the Office of Patient Protection is $25.00. This payment should be sent to the Office of Patient Protection, along with your written request for a review. This fee may be waived by the OPP if it determines that the payment of the fee would result in an extreme financial hardship to you. The remainder of the cost for an external review shall be borne by the Plan. Upon completion of the external review, the Office of Patient Protection shall bill the Plan the amount established pursuant to contract between the Department and the assigned external review agency minus the $25 fee which is your responsibility. In connection with any request for an external review, Tufts Health Plan shall assure that you or your authorized representative, have access to any medical information and records relating to your grievance, in the possession of the Plan or under its control. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. The review panel may order the continuation of coverage where it determines that substantial harm to your health may result absent such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage shall be at the Plan's expense regardless of the final external review determination. The decision of the review panel shall be binding.

Member Satisfaction Process, Continued

Expedited Grievance

In "Time Sensitive" situations, the Plan will respond to your grievance on an expedited basis. A Time-Sensitive situation is one in which waiting for a standard decision could seriously jeopardize your life, health, or ability to regain maximum function. Under these circumstances, you will be notified of our decision within 72 hours after the review is initiated. Written confirmation of the Plan's decision will be sent to you within 2 business days after such notification.

- If you are an Inpatient in a hospital: the Plan will notify you of its decision before you are discharged.
- If you are grieving denied coverage: if the Plan does not notify you of its decision within 48 hours, and if your physician tells us that in his or her opinion the service or Durable Medical Equipment at issue is Medically Necessary and denial of coverage will create a substantial risk of serious harm that is so immediate that the provision of services should not wait for the outcome of the appeal, the Plan will provide the denied coverage until it notifies you of the Plan's decision.
- If you are grieving coverage for Durable Medical Equipment that the Plan determined was not Medically Necessary: if your physician tells the Plan that in his or her opinion the service at issue is Medically Necessary and certifies the specific immediate and severe harm that will result if you do not have coverage for the denied Durable Medical Equipment sooner than 48 hours, the Plan will provide coverage until it notifies you of Tufts Health Plan's decision.
- If you have a terminal illness, the Plan will notify you of the Plan's decision within 5 days of receiving your appeal. The decision will include the specific medical and scientific reasons for denying the coverage, and a description of any alternative treatment, services or supplies that would be covered.

  If you have a terminal illness and the Plan's decision is to deny coverage, you may request a conference.

  - The Plan will schedule the conference within 10 days (or within 5 business days if your physician determines, after talking with a Tufts Health Plan medical director, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date).
  - You may bring another person with you to the conference.

For further assistance

The Plan has discretionary authority to make final and binding decisions regarding its member satisfaction process. However, if you are not satisfied with the Plan member satisfaction process, you shall have the right at any time to contact the Commonwealth of Massachusetts at either:

- the Division of Insurance Bureau of Managed Care at 617-521-7777; or
- the Department of Public Health's Office of Patient Protection at 1-800-436-7757.

If You Have Concerns

Quality of Medical Care

If you have concerns about your medical care, you should discuss them directly with the Provider. You may also:

- call a Member Services Coordinator at 1-800-870-9488; or
- write to a Member Grievance Analyst at:

  Tufts Health Plan
  Attn: Appeals and Grievances Dept.
  333 Wyman Street
  P.O. Box 9112
  Waltham, MA 02454-9112

The Plan's Quality Improvement staff will review your concerns and will respond within 30 days.

Note: Your name will not be disclosed to the Provider without your consent.

Adminis-trative Concerns

If you have administrative concerns about the Plan, you should:

- call a Member Services Coordinator at 1-800-870-9488; or
- write to a Member Grievance Analyst at:

  Tufts Health Plan
  Attn: Appeals and Grievances Dept.
  333 Wyman Street
  P.O. Box 9112
  Waltham, MA 02454-9112

Concerns related to Plan employees, departments, processes or policies which have no impact on your medical care are processed as administrative grievances. Administrative grievances will be brought to the attention of the employee's manager to assess and take appropriate action.

The Plan will review your concerns and will respond within 30 calendar days.

Bills from Providers

Bills from Providers

Occasionally, you may receive a bill from a Provider for Covered Services. Do not pay the bill. Instead, send it to the Member Services Department.

If you do pay the bill, send the following to the Member Services Department:

- a copy of the bill; and
- proof that you paid, such as a receipt or copies of both sides of the canceled check(s).

Send bills to the Plan within six months after the date you received care. If you do not, the bill cannot be considered for payment.

If you receive Covered Services from a non-Plan Provider, the Plan will pay you up to the Reasonable Charge for the services.

The Plan reserves the right to be reimbursed by the Member for payments made due to Tufts Health Plan's error.

Limitation on Actions

Limitation on Actions

You cannot file a lawsuit against the Plan for failing to pay or arrange for Covered Services unless you have completed the Plan's Internal Grievance Process and file the lawsuit within two years from the time the cause of action arose.

Chapter 6

Other Plan Provisions

Overview

Introduction This chapter contains the following topics.

Subrogation

The Plan's right of subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else; for example:

- a worker's compensation insurer,
- your own or someone else's auto or homeowner's insurer, or
- the person who caused your illness or injury.

In that case, if the Plan pays or will pay for the costs of health care services given to treat your illness or injury, the Plan has the right to recover those costs in your name, with or without your consent, directly from that person or company. This is called the Plan's right of subrogation. The Plan's right has priority, except as otherwise provided by law. The Plan can recover against the total amount of any recovery, regardless of whether

- all or part of the recovery is for medical expenses, or
- the recovery is less than the amount needed to reimburse you fully for the illness or injury.

Continued on next page

Subrogation, Continued

The Plan's right of reimbursement

If you use your legal right to recover money by a lawsuit, settlement or otherwise, and you recover money, the Plan has the right to be reimbursed by you. In this case, you must repay the Plan for the cost of health care services and supplies that the Plan paid or will pay, up to the total amount of your recovery.

Assignment of benefits

You hereby assign to the Plan any benefits you may be entitled to receive from a person or company that caused, or is legally responsible to reimburse you for your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses, that the Plan paid or will pay for your illness or injury.

Member cooperation

You agree:

- to notify the Plan of any events which may affect the Plan's rights of recovery under this section, such as:
  - injury resulting from an automobile accident, or
  - job-related injuries that may be covered by workers' compensation;
- to cooperate with the Plan by
  - giving the Plan information and help, and
  - signing documents to help the Plan get reimbursed;
- that the Plan may
  - investigate,
  - request and release information which is necessary to carry out the purpose of this section to the extent allowed by law, and
  - do the things the Plan decides are appropriate to protect the Plan's rights of recovery.

Subrogation Agent

The Plan may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as the Plan's agent.

Coordination of Benefits

Benefits under other plans

You may have benefits under other plans for hospital, medical, dental or other health care expenses.

The Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for Covered Services with benefits payable by other plans, consistent with state law.

Note: We coordinate benefits with Medicare according to federal law, rather than state law.

Primary and secondary plans

The Plan will coordinate benefits by determining
- which plan has to pay first when you make a claim, and
- which plan has to pay second.

The Plan will make these determinations according to applicable state law.

Right to receive and release necessary information

When you enroll, you must include information on your membership application about other health coverage you have.

After you enroll, you must notify the Plan of new coverage or termination of other coverage. The Plan may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with the Plan's COB program.

Right to recover overpayment

The Plan may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. The Plan will recover only overpayments actually made.

For more information

For more information about COB, call a Member Services Coordinator at 1-800-870-9488 and have your call transferred to the Plan's Liability Recovery (COB) Department.

Use and Disclosure of Medical Information

The Plan mails a separate *Notice of Privacy Practices* to all Subscribers to explain how the Plan uses and discloses your medical information. If you have questions or would like another copy of the Plan's *Notice of Privacy Practices*, please call Member Services at 1-800-870-9488. Information is also available on the Plan's Web site at **www.tuftshealthplan.com**.

Relationships between the Plan and Providers

The Plan and Providers

The Plan arranges health care services. The Plan does not provide health care services. The Plan has agreements with Providers practicing in their private offices throughout the Service Area. These Providers are independent. They are not Plan employees, agents or representatives. Providers are not authorized to:

- change this Evidence of Coverage; or
- assume or create any obligation for the Plan.

The Plan is not liable for acts, omissions, representations or other conduct of any Provider.

Circumstances Beyond the Plan's Reasonable Control

Circumstances beyond the Plan's reasonable control

The Plan shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of the Plan. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, the Plan will make a good faith effort to arrange for the provision of services. In doing so, the Plan will take into account the impact of the event and the availability of Plan Providers.

Group Contract

Acceptance of the terms of the Group Contract

By signing and returning the membership application form, you apply for Group coverage and agree to all the terms and conditions of the Group Contract, including this Evidence of Coverage.

Payments for coverage

The Plan will bill the Group Insurance Commission and the GIC will pay Premiums to the Plan for you. The Plan is not responsible if the Group Insurance Commission fails to pay the Premium. This is true even if the Group Insurance Commission has charged you (for example, by payroll deduction) for all or part of the Premium.

Note: If the Group Insurance Commission fails to pay the Premium on time, the Plan may cancel your coverage in accordance with the Group Contract and applicable state law.

The GIC may change the Premium. If the Premium is changed, the change will apply to all Members in your Group.

Continued on next page

Changes to this Evidence of Coverage

The Plan may change this Evidence of Coverage subject to GIC approval. Changes do not require your consent. Notice of changes in Covered Services will be sent to the Commission at least 60 days before the effective date of the modifications and will

- include information regarding any changes in clinical review criteria; and
- detail the effect of such changes on a Member's personal liability for the cost of such changes.

An amendment to this Evidence of Coverage describing the changes will be sent to you and will include the effective date of the change. Changes will apply to all benefits for services received on or after the effective date with one exception.

Exception: A change will not apply to you if you are an Inpatient on the effective date of the change until the earlier of:

- your discharge date, or
- the date Annual Coverage Limitations are used up.

Note: If changes are made, they will apply to all Members, not just to you. At least once every five years, we will send you a new Evidence of Coverage incorporating all of the changes.

Notice

Notice to Members: We may send notice to you of information affecting your Tufts Health Plan coverage. When we send a notice to you, it will be sent to your last address on file with us. The Plan usually will not send notices to you. The Plan will send each notice to the Commission.

Notice to us: Members should address all correspondence to:

Tufts Health Plan,
705 Mt. Auburn Street, P.O. Box 9166,
Watertown, MA 02471-9166

Enforcement of terms

The Plan may choose to waive certain terms of the Group Contract, if applicable, including the Evidence of Coverage. This does not mean that the Plan gives up its rights to enforce those terms in the future.

When this Evidence of Coverage is Issued and Effective

This Evidence of Coverage is issued and effective July 1, 2003 and supersedes all previous Evidences of Coverage.

Appendix A

Glossary of Terms

Terms and Definitions

Term/ definition table The table below defines the terms used in this Evidence of Coverage.

Term	Definition
Annual Coverage Limitations	Annual dollar or time limitations on Covered Services.
Authorized Reviewer	Authorized Reviewers review and approve certain services and supplies to Members. They are: • the Plan's Chief Medical Officer (or equivalent); or • someone he or she names.
Benefit Period	The way that Medicare measures your use of hospital and skilled nursing facility services. A Benefit Period begins the day you go to a hospital or skilled nursing facility. The Benefit Period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new Benefit Period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of Benefit Periods you can have.
Coinsurance	The percentage of costs you must pay for certain Covered Services. For services provided by a Non-Plan Provider, your share is a percentage of the Reasonable Charge for those services. For services provided by a Plan Provider, your share is a percentage of: • the applicable Plan fee schedule amount for those services; and • the Plan Provider's actual charges for those services, whichever is less.
Copayment	Fees you pay for Covered Services. Copayments are paid to the Provider when you receive care unless the Provider arranges otherwise.
Cosmetic Services	Services performed solely for the purpose of improving appearance, which appearance is not the result of accidental injury, congenital anomoly or a previous surgical procedure or disease.

Terms and Definitions, Continued

Term	Definition
Covered Services	The services and supplies for which the Plan will pay. Note: Covered Services do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any Provider, Member, service, supply, or medication.
Covering Physician	The physician named by your PCP to give or authorize services in your PCP's absence.
Custodial Care	• Care given primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety; • care given primarily for maintaining the Member's or anyone else's safety, when no other aspects of treatment require an acute hospital level of care; • services that could be given by people without professional skills or training; • routine maintenance of colostomies, ileostomies, and urinary catheters; or • adult and pediatric day care. In cases of mental health care, inpatient care given primarily • for maintaining the Member's or anyone else's safety, or • for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute hospital level of care. Note: Custodial Care is not covered by the Plan.
Day Surgery	Any surgical procedure(s) in an operating room under anesthesia for which the Member is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day. For hospital census purposes, the Member is an Outpatient not an Inpatient.
Deductible	The amount you must pay for health care, before Medicare begins to pay for Medicare Covered Services. There is a Deductible for each Benefit Period for Part A, and each year for Part B. These amounts can change every year.
Designated Facility for Inpatient Mental Health/ Inpatient Substance Abuse Services	A facility licensed to treat Mental Conditions and / or substance abuse (alcohol and drug). This facility has an agreement with the Plan to provide Inpatient or day treatment services to Members assigned to the facility.

Term	Definition
Directory of Health Care Providers	A separate booklet which lists • Plan PCPs and their affiliated Plan Hospital; and • certain other Plan Providers. Note: This booklet is updated from time to time to show changes in Providers affiliated with the Plan. For information about the Providers listed in the *Directory of Health Care Providers*, you can call Member Services at 1-800-870-9488 or check the Plan's web site at **www.tuftshealthplan.com**.
Durable Medical Equipment	Devices or instruments of a durable nature that • are reasonable and necessary to sustain a minimum threshold of independent daily living; • are made primarily to serve a medical purpose; • are not useful in the absence of illness or injury; • can withstand repeated use; and • can be used in the home.
Effective Date	The date, according to the Plan's records, when you become a Member and are first eligible for Covered Services.
Emergency	An illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in: • serious jeopardy to the physical and / or mental health of a Member or another person (or with respect to a pregnant Member, the Member's or her unborn child's physical and / or mental health); • serious impairment to bodily functions; or • serious dysfunction of any bodily organ or part; or • with respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the Member or her unborn child in the event of transfer to another hospital before delivery.
Evidence of Coverage	This document and any future amendments.

Terms and Definitions, Continued

Term	Definition
Experimental or Investigative	A service, supply, treatment, procedure, device, or medication (collectively "treatment") is Experimental or Investigative if any of the following is true: • the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or • the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or • reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or • reliable evidence shows that prevailing opinion among experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis. Note: Reliable evidence, as used in this section, shall mean only published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment; or the written informed consent form used by the treating facility or by another facility studying substantially the same treatment.
Group	The Group Insurance Commission, with whom Tufts Health Plan has an agreement to provide group coverage.
Group Anniversary Date	The date upon which the Group Contract first renews and each successive annual renewal date.
Group Insurance Commission	The Massachusetts state agency responsible for purchasing this health care program for employees and retirees of the Commonwealth of Massachusetts. Also referred to as "the Commission" or "GIC."

Terms and Definitions, Continued

Term	Definition
Group Contract	The agreement between Tufts Health Plan and the Group Insurance Commission under which • Tufts Health Plan agrees to provide Group coverage to you; and • the Group Insurance Commission agrees to pay a Premium to the Plan on your behalf. The Group Contract includes this Evidence of Coverage and any amendments.
Individual Coverage	Coverage for a Subscriber only.
Inpatient	A patient who is • admitted to a hospital or other facility licensed to provide continuous care; and • classified as an Inpatient for all or a part of the day on the facility's Inpatient census.

Terms and Definitions, Continued

Term	Definition
Medically Necessary	A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply: • Is the most appropriate available supply or level of services for the Member in question considering potential benefits and harms to that individual; • Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or • for services and interventions not in widespread use, is based on scientific evidence. In determining coverage for Medically Necessary Services, the Plan uses guidelines which are: • developed with input from practicing physicians in the Service Area; • developed in accordance with the standards adopted by national accreditation organizations; • updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and • evidence-based, if practicable. Note: For those services covered by Medicare, Medicare determines what is Medically Necessary.
Member	A person enrolled in Tufts Health Plan under the Group Contract. Also referred to as "you."
Mental Disorders	Psychiatric illnesses or diseases listed as Mental Disorders in the latest edition, at the time treatment is given, of the *American Psychiatric Association's Diagnostic and Statistical Manual: Mental Disorders* regardless of whether the cause of the illness or disease is organic.
Open Enrollment Period	The period each year when the Group Insurance Commission allows eligible persons to apply for coverage under this Plan and any other health plans offered by the GIC.

Terms and Definitions, Continued

Term	Definition
Outpatient	A patient who receives care other than on an Inpatient basis. This includes services provided in: a physician's office; a Day Surgery or ambulatory care unit; and an Emergency room or outpatient clinic. Note: You are also an Outpatient when you are in a facility for observation.
The Plan	See Tufts Health Plan.
Plan Hospital	See Tufts Health Plan Hospital.
Plan Provider	See Tufts Health Plan Provider.
Premium	The total monthly cost of Individual Coverage which the Group Insurance Commission pays to Tufts Health Plan.
Primary Care Physician (PCP)	The Tufts Health Plan physician you have chosen from the *Directory of Health Care Providers* and who has an agreement with the Plan to provide primary care and to coordinate, arrange, and authorize the provision of Covered Services.
Provider	A health care professional or facility licensed in accordance with applicable state law, including, but not limited to, hospitals, physicians, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, licensed speech-language pathologists, and licensed audiologists. The Plan will only cover services of a Provider, if those services are: • listed as Covered Services; and • within the scope of the Provider's license.
Provider Unit	A Provider Unit is comprised of doctors and other health care Providers who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care. Also referred to as "Provider Group".
Reasonable Charge	The lesser of the: • amount charged; or • amount that the Plan determines, based upon the fees most often charged by similar Providers for the same service in the geographic area in which it is given, to be the reasonable amount for the service.

Terms and Definitions, Continued

Term	Definition
Reserve Days	Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days of Medicare Covered Services. These 60 Reserve Days can be used only once during your lifetime. For each lifetime Reserve Day, Medicare pays all covered costs except for a daily Coinsurance amount.
Service Area	The Service Area (sometimes referred to as the "Enrollment Service Area"), which is the geographical area within which the Plan has developed a network of Providers to afford Members with adequate access to Covered Services. The Enrollment Service Area consists of the Primary Service Area and the Extended Service Area. The Primary Service Area is comprised of: • all of Massachusetts, except Nantucket and Martha's Vineyard; and • the cities and towns in New Hampshire and Rhode Island in which Plan PCPs are located. The Extended Service Area includes certain towns in Connecticut, New Hampshire, Rhode Island and Vermont which surround the Primary Service Area and are within a reasonable distance to the location of Primary Care Physicians. Notes: • There are generally no Plan PCPs located within the Extended Service Area. • For a list of cities and towns in the Service Area, you can call Member Services at 1-800-870-9488 or check the Plan's web site at **www.tuftshealthplan.com**.
Spouse	The Subscriber's legal spouse, according to the law of the state in which you reside.
Skilled	A type of care which is Medically Necessary and must be provided by, or under the direct supervision of, licensed medical personnel. Skilled care is provided to achieve a medically desired and realistically achievable outcome.

Terms and Definitions, Continued

Term	Definition
Subscriber	The person who • is an employee of the Commonwealth of Massachusetts, Medicare eligible retired employee, or Medicare eligible surviving spouse of an employee or retiree; • enrolls in this Plan and signs the membership application form on behalf of himself or herself; and • in whose name the Premium is paid.
Tufts Health Plan or the Plan	Tufts Associated Health Maintenance Organization, Inc., a Massachusetts corporation d/b/a Tufts Health Plan. Tufts Health Plan is licensed by Massachusetts as a health maintenance organization (HMO). Also referred to as "the Plan".
Tufts Health Plan Hospital or Plan Hospital	A hospital which has an agreement with Tufts Health Plan to provide certain Covered Services to Members. Plan Hospitals are independent. They are not owned by Tufts Health Plan. Plan Hospitals are not Tufts Health Plan's agents or representatives, and their staff are not Tufts Health Plan's employees.
Tufts Health Plan Provider or Plan Provider	A Provider with which Tufts Health Plan has an agreement to provide Covered Services to Members. Providers are not Tufts Health Plan's employees, agents or representatives.
Urgent Care	Care needed to prevent serious deterioration of health. Examples of conditions requiring Urgent Care are: • a sprained ankle, • broken bone(s), • an earache, • strep throat, • high fever, or • a laceration requiring stitches.
Usual and Customary Charge	See "Reasonable Charge".

Appendix B – Non-Covered Drugs With Suggested Alternatives*

This list of non-covered drugs is effective January 1, 2003 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter.

IMPORTANT NOTE: Please see the Plan's Web site at **www.tuftshealthplan.com** for the most current list or call Member Services at 1-800-870-9488.

Brand Name	Suggested Alternatives and Additional Information
Axid	ranitidine or cimetidine (Tier-1, lowest copayment)
Beconase	Nasacort, Rhinocort (Tier-2, middle copayment)
Beconase AQ	Nasacort AQ, Flonase, Nasonex (Tier-2, middle copayment)
Bextra	ibuprofen, indomethacin, naproxen, naproxen sodium, sulindac (Tier-1, lowest copayment)
Capoten	captopril (Tier-1, lowest copayment)
Ceclor CD 375 mg	cefaclor 250mg, 500mg, cefaclor ER (Tier-1, lowest copayment)
Dynacin	minocycline HCl (Tier-1, lowest copayment)
EC Naprosyn	enteric coated naproxen (Tier-1, lowest copayment)
Flagyl 375mg, Flagyl ER 750 mg tablets	metronidazole 250 mg, 500 mg (Tier-1, lowest copayment)
Klonopin	clonazepam (Tier-1, lowest copayment)
Lidex , Lidex E	fluocinonide and fluocinonide E (Tier-1, lowest copayment)
Lopressor	metoprolol (Tier-1, lowest copayment)
Lupron 1mg/ 0.2mL vial and kit	leuprolide 1mg/0.2 mL vial and kit (Tier-1, lowest copayment) (Prior Authorization required for males age 25 and older)
Mevacor	lovastatin (Tier-1, lowest copayment)
Micardis	Diovan and Cozaar (Tier-2, middle copayment)
Micardis HCT	Diovan HCT and Hyzaar (Tier-2, middle copayment)
Minocin	minocycline HCl (Tier-1, lowest copayment)

**Also referred to as "Prescription Alternative Program"*

Non-Covered Drugs With Suggested Alternatives, Continued

Brand Name	Suggested Alternatives and Additional Information
Monistat Dual-Pak	miconazole or clotrimazole OTC (not covered), Diflucan 150mg (Tier-2, middle copayment) or Terazol 3/7 (Tier-3, highest copayment)
Monodox	doxycycline hyclate (Tier-1, lowest copayment)
Naprelan	naproxen (Tier-1, lowest copayment)
Pepcid (except suspension)	famotidine (Tier-1, lowest copayment)
Prinivil	lisinopril (Tier-1, lowest compayment)
Prinzide	lisinopril/HCTZ (Tier-1, lowest copayment)
Relenza	amantadine (Tier-1, lowest copayment)
Tamiflu	amantadine (Tier-1, lowest copayment)
Tequin	Avelox,Cipro or Levaquin (Tier-2, middle copayment)
Valium	diazepam (Tier-1, lowest copayment)
Vasotec	enalapril (Tier-1, lowest copayment)
Vectrin	minocycline HCl (Tier-1, lowest copayment)
Vicoprofen	hydrocodone with acetaminophen combination products or ibuprofen alone(Tier-1, lowest copayment)
Xanax	alprazolam (Tier-1, lowest copayment)
Zocor	Lipitor, Pravachol, and Lescol (Tier-2, middle copayment)
Zyrtec D	Allegra D or Claritin D, (Tier-3, highest copayment)
Zyrtec Please note: Zyrtec liquid and tablets will be covered for members age 12 and under (Tier 3, highest copayment)	Allegra or Claritin, (Tier-3, highest copayment), or nasal corticosteriod such as Flonase, Nasacort, Nasacort AQ, Nasonex, Rhinocort, Rhinocort AQ, or Tri-Nasal (Tier-2, middle copayment)